



CAQH Credentialing Cover Sheet

Adding a Provider to an existing contract only

Application Instructions:

- Thank you for your interest in adding a Provider to your existing contract.
- Please complete this CAQH Credentialing Cover Sheet in its entirety.
- Incomplete forms may be returned and/or not processed timely.
- Please type or print legibly.

Submission Instructions:

- Download and complete additional documents listed on iehp.org (insert link)
- Once completed, send the following forms to jointhenetwork@iehp.org:
 - CAQH Credentialing Cover Sheet
 - Proof of Medi-Cal enrollment OR proof of Medi-Cal enrollment application

CONTRACT INFORMATION

Provider will be credentialed under the following contract:

Contract Name: _____

Contract TIN: _____

Contract Type: _____

ENTITY CONTACT INFORMATION

Please provide the best point of contact:

Entity Contact Name: _____

Entity Contact Email: _____

Entity Contact Phone Number: _____



PROVIDER INFORMATION

First Name: _____ Last Name: _____

CAQH ID: _____ Last CAQH Attested Date: _____

Global or plan-specific access granted: ☐ Yes ☐ No

Provider NPI: _____

Provider License #: _____

Provider Specialty: _____

Is this provider **telehealth-only**? ☐ Yes ☐ No
(If yes, do not list addresses below)

Primary Practice Location Address: _____

Secondary Practice Location Address: _____

Tertiary Practice Location Address: _____

ADDITIONAL PROVIDER(S)

First Name: _____ Last Name: _____

CAQH ID: _____ Last CAQH Attested Date: _____

Global or plan-specific access granted: ☐ Yes ☐ No

Provider NPI: _____

Provider License #: _____

Provider Specialty: _____

Is this provider **telehealth-only**? ☐ Yes ☐ No
(If yes, do not list addresses below)

Primary Practice Location Address: _____

Secondary Practice Location Address: _____

Tertiary Practice Location Address: _____



First Name: _____ Last Name: _____

CAQH ID: _____ Last CAQH Attested Date: _____

Global or plan-specific access granted: ☐ Yes ☐ No

Provider NPI: _____

Provider License #: _____

Provider Specialty: _____

Is this provider **telehealth-only**? ☐ Yes ☐ No

(If yes, do not list addresses below)

Primary Practice Location Address: _____

Secondary Practice Location Address: _____

Tertiary Practice Location Address: _____

First Name: _____ Last Name: _____

CAQH ID: _____ Last CAQH Attested Date: _____

Global or plan-specific access granted: ☐ Yes ☐ No

Provider NPI: _____

Provider License #: _____

Provider Specialty: _____

Is this provider **telehealth-only**? ☐ Yes ☐ No

(If yes, do not list addresses below)

Primary Practice Location Address: _____

Secondary Practice Location Address: _____

Tertiary Practice Location Address: _____



ENTITY ATTESTATION

1. IEHP Access Authorization

I confirm that each applying provider has granted authorization in CAQH for **IEHP** to access their profile (global or plan-specific access).

☐ Yes

☐ No (please explain): _____

2. Medicare and Medi-Cal Participation Accuracy

I confirm that **Section 1 (Other ID Numbers)** in each provider's CAQH profile accurately reflects the provider's participation in **Medicare** and **Medi-Cal** programs, consistent with the practice's contracted lines of business.

☐ Yes

☐ No (please explain): _____

3. Required IEHP Documents Uploaded to CAQH

I confirm that all IEHP-required documents have been uploaded to each provider's CAQH profile

☐ Yes

☐ No (please explain): _____

4. Office Hours Updated for All Practice Locations

I confirm that office hours for each practice location listed in CAQH are current, complete, and accurate.

☐ Yes

☐ No (please explain): _____

Signature: _____

Print Name: _____

Date: _____